LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

JOINT
COMMISSION ON HIV/
PREVENTION PLANNING COMMITTEE
MEETING MINUTES
October 5, 2011

COMMISSION MEMBERS PRESENT	PPC MEMBERS PRESENT	COMMISSION MEMBERS ABSENT	COMMISSION STAFF/CONSULTANTS
Carla Bailey, *Co-Chair*/Kevin Lewis	Michael Green, *Co-Chair*	Al Ballesteros	Diane Burbie
Michael Johnson, *Co-Chair*	Ricki Rosales, *Co-Chair*	Anthony Braswell	Dawn McClendon
Sergio Aviña	Sophia Rumanes, *Co-Chair*	Nettie DeAugustine	Jane Nachazel
Joseph Cadden	Terry Smith, *Co-Chair*	Whitney Engeran-Cordova	Glenda Pinney
Lilia Espinoza	Juli-Ann Carlos	Douglas Frye	James Stewart
Aaron Fox*	John Copeland	David Giugni*	Craig Vincent-Jones
Terry Goddard	Trevor Daniels	Joseph Green	Nicole Werner
Thelma James	Michelle Enfield	Quentin O'Brien	Donna Yutzy
David Kelly	Aaron Fox*	Angélica Palmeros	
Lee Kochems	Jeffrey Goodman	Karen Peterson	
Bradley Land	Heather Grant	Stephen Simon	**DHSP STAFF**
Ted Liso	Anthony Gutierrez		Kyle Baker
Anna Long	AJ King		Elizabeth Escobedo
Abad Lopez	Victor Martinez	**PPC MEMBERS ABSENT**	Sanali Kulkarni
Elizabeth Mendia	Jill Rotenberg	Scott Campbell	Cheryl Williams
Jenny O'Malley	Enrique Topete	Ryyn Chua	Juhua Wu
Mario Pérez	Kathy Watt*	David Giugni*	
Juan Rivera	Timothy Young	Grissel Granados	
Robert Sotomayor		Brian Lew	
Carlos Vega-Matos		Milton Smith	
Tonya Washington-Hendricks			
Kathy Watt*			
Fariba Younai		** Indicates dual Commission and PPC membership*	

PUBLIC			
Ernesto Aldano	Shawn Griffin	Cara O'Connor	John Walt Senterfitt
Victor Ashly	Richard Hamilton	Stuart Pappas	Jason Tran
H. Avilez	Luke Klipp	Terri Reynolds	Becky Vanderzee
Michael Buimon	Frank Lewis	Brian Risley	Sharon White
Zoyla Cruz	Richard Maales	Daniel Rivas	Jason Wise
Susan Forrest	Gil Montgomery	Natalie Sanchez	Richard Zalnar
Ramon Garcia	Ldano Navarro		

1. **REGISTRATION**: Registration opened at 8:15 am.

2. **CALL TO ORDER**:
   - **A. Welcome**: Mr. Johnson and Mr. Smith opened the meeting at 9:05 am.
   - **B. Roll Call (Present)**:
     - *Commission*: Cadden, Fox*, Johnson, Lewis, Liso, Long, Lopez, Pérez, Rivera, Vega-Matos, Washington-Hendricks, Watt*
     - *PPC*: Carlos, Copeland, Enfield, Fox*, Gutierrez, King, Martinez, Rotenberg, Rumanes, Terry Smith, Topete, Watt*, Young

3. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**:
   - Mr. Risley, AIDS Project Los Angeles (APLA), reported release of a new hard copy edition of "HIV LA" published by APLA for the Department of Public Health (DPH). It is updated as of 9/30/2011. APLA does not have funding for a large print run, but will distribute about 50 copies each to approximately two dozen providers. The print edition is targeted to clients who lack Internet access. He pointed out "HIV LA" has been primarily an online resource for about two years. He urged providers to use that version, at www.hivla.org, which is updated weekly. Fact sheets and an updated pdfs are also available online.
   - Mr. Martinez announced Bienestar is hosting the Testimony of Hope at the Mexican Consulate on 10/7/2011, 6:00 to 8:00 pm. The event is in conjunction with National Latino AIDS Awareness Day.

4. **COMMISSION/PPC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

5. **APPROVAL OF AGENDA**:
   - **A. Agenda Review**: **MOTION 1**: Approve the Agenda Order ***(Passed by Consensus)***.

6. **CONTEXT FOR CHANGE IN HIV PLANNING**:
   - **A. Purpose of the Meeting**:
     - Ms. Burbie, Facilitator, said the meeting was an opportunity for the Commission and PPC to collectively position Los Angeles County to be the most competitive, viable and forward-moving jurisdiction in the country. Each body brings a valuable piece of the solution for LA County's complexity as changes roll out for prevention and care. This meeting would define first steps.
     - She emphasized the meeting was not designed to develop a finished plan, but to raise strategic planning from the committee to the body level. The County's funding, viability and influence going forward rest on that work.
     - The day would provide an overview of recent changes to prevention and care guidance, discussion of service provision complexities/barriers, current work in the County and other jurisdictions. The day would conclude with action planning.
   - **B. Why the Time is Right for a New Way of Planning**:
     - **1. *Commission on HIV***:
       - Mr. Vincent-Jones, Executive Director, Commission, noted integrated care and prevention planning is not a new concept to the Health Resources Services Administration (HRSA), which administers the Ryan White (RW) grant. It has gained strength over time and is becoming more institutionalized in care requirements.
       - HRSA's Part A Manual has long included a collaborative care/prevention planning section and notes pertinent RW legislation. It also cites Early Intervention Services (EIS) and outreach. Part C grants fund EIS.
       - HRSA states, "Coordination of care and prevention planning can help bridge gaps across prevention and care and thus help individuals learn their HIV status and enter care if infected." HRSA also cites benefits in better use of resources such as in compiling data and reducing meetings as well as better services by linking people to care.
       - The Part A Manual notes a range of collaborative efforts from sharing information to planning tasks such as a combined resource inventory up to merging care/prevention planning bodies in whole or in part.
       - HRSA considers RW legislation to require collaboration in: planning body membership, e.g., PPC members on the Commission; priority-setting and resource allocation, e.g., allocations to EIS; coordination in service provision; comprehensive care/prevention planning in specific pieces; key access points to ensure links through the care and prevention continuum; and prevention of perinatal transmission, addressed primarily through Part D.
       - HRSA has specific expectations for planning body membership, planning, services and perinatal transmission.
       - HRSA suggests asking several questions to start care/prevention collaborative planning: What is it? Why undertake it, i.e., what are the benefits? What are the obstacles? What factors encourage it? What action is needed to begin?

- Benefits cited by HRSA are: reduced meeting time, more comprehensive epidemiological profiles, reduced needs assessment time/costs, improved linkages, earlier diagnosis/entry into care with consequent reduction in unmet need and improved health outcomes, improved secondary prevention, and better care/prevention understanding.
- Obstacles noted by HRSA are: concerns about time/effort required, concerns about overly broad collaboration that is ineffective, fear prevention will receive reduced attention, and different planning body perspectives.
- Factors cited that encourage collaboration are: shared interest in more efficient and responsive planning, key leadership commitment, jurisdiction size and scope, and coordination of public health activities. For example, Mr. Vincent-Jones noted that the County is the only UCHAPS jurisdiction with the same care/treatment and prevention boundaries.
- National HIV/AIDS Strategy (NHAS) supports collaboration with goals to: reduce number infected; increase care/ optimize health outcomes; reduce HIV-related health disparities. Federal departments developed implementation plans with HRSA consistently partnering with CDC. HRSA's operational goals are: integrate HIV testing, outreach and retention; facilitate linkage into care; co-locate screening/testing and care; integrate prevention and care.
- The RW Treatment Extension Act of 2009 governing the Part A application for the first time required RW jurisdictions to identify those unaware and move them into care, significantly affecting how applications are scored.
- Two-thirds of Part A application funding is based on a formula using prevalence and incidence. One-third, however, is determined by a competitive supplemental application with a total 100 available points.
- The Early Identification of Individuals with HIV/AIDS (EIIHA) initiative represents 33 of those points. It requires increasing: those aware of their status; PLWH in care, specifically medical care; and HIV- referred to services that help keep them HIV-. Points are earned based on the soundness of the plan which requires specific testing targets.
- An additional 34 supplemental application points represent unmet need. Application language also seems to permit funding more prevention such as counseling/testing and outreach than allowed prior to reauthorization.
- The County is one of twelve Enhanced Comprehensive HIV Prevention Planning (ECHPP) Metropolitan Statistical Areas (MSAs). New this year, the Part A application narrative must identify NHAS goals supported by collaborative Part A program and ECHPP initiative efforts, including timelines and responsible parties.
- The Planning Council must also submit a Comprehensive Plan to HRSA every three years, in conjunction with DHSP, PPC and other stakeholders. The next Plan is due in May 2012 for FYs 2012-2014. It is meant to be a blueprint for the jurisdiction to comprehensively address the continuum of HIV care. Previously the Comprehensive Care Plan, the deletion of "Care" from the title subtly signals a shift to addressing the full continuum, including prevention.
- Among new sections are responses on EIIHA, NHAS and the Affordable Care Act (ACA)/Health Care Reform (HCR). The ACA/HCR section must outline how the continuum will respond to changes as it: eliminates disparities in health care; strengthens public health/health care access; and encourages consumer/patient wellness.
- Each section of the guidance specifically requires planning councils to address prevention:
  - "Where Are We Now?" requires a description of prevention and service needs.
  - "Where Do We Need To Go?" requires: goals for those unaware of their status (EIIHA); a description of coordination efforts with prevention programs, including Partner Notification and Prevention with Positives; and a description of RW program collaboration with the EIIHA initiative.
  - "How Will We Get There?" requires strategy, plan, activities and responsible parties to: address needs of the unaware; implement proposed coordinating efforts; address NHAS goals, as well as specific related goals.
  - "How Will We Monitor Progress?" requires strategy, plan, activities and responsible parties to monitor and evaluate progress on proposed goals and identified challenges, including assessment of the EIIHA impact.
- Mr. Vincent-Jones noted care has moved over the past decade toward integrated planning from recommendations to direct requirements. That opens a door and presents challenges which spurred the impetus to meet jointly.

2. ***Division of HIV and STD Programs (DHSP)***:

- Mr. Pérez affirmed many things are impacting how the system of care is addressed, such as NHAS, HCR, ECHPP and Program Collaboration and Service Integration (PCSI) at the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). Dr. Kevin Fenton, Director, NCHHSTP, continues to emphasize the merging of disease control disciplines into single units, despite resistance from the traditional CDC silo structure.
- Science provides data on effective approaches and promising areas, e.g., the HIV Prevention Trials Network 052 study showed earlier diagnosis and treatment can lead to significant interruption in transmissions.
- Mr. Pérez added that social and environmental conditions also affect disease transmission rates and health outcomes among those served, e.g., unemployment, poverty, drug abuse and poor graduation rates.

- DPH itself is addressing aspects of integration with the 2/2/2011 announcement by Jonathan Freedman, Chief Deputy Director, integrating the STD Control Program, HIV Epidemiology Program and the Office of AIDS Programs and Policy under DHSP. The integration process is not yet complete, but is proceeding.
- The estimates of total PLWHA countywide are refined as HIV epidemiology and surveillance tools improve. The latest estimate suggests a slight decline from 62,800 to 61,700 PLWHA over the last three years. San Francisco has similarly reported a clear decline in new infections. NHAS goals set a clear challenge for accelerated improvement.
- Data presentations going forward will stress intersections between HIV and STDs. Several concerns are highlighted in a 2009 report on HIV/STD Co-morbidity Among HIV Cases Reported for Partner Services. A significant number of men living with HIV and in care are being diagnosed with syphilis, raising questions about prevention opportunities. Increased rectal and vaginal gonorrhea rates among PLWH raise questions about HIV transmission patterns. The intersection between HIV and chlamydia is less, but speaks to those acquiring repeated STDs prior to HIV.
- The continuum of HIV services reflects that about 21% of the estimated 1.2 million American PLWH are diagnosed, in care and have suppressed Viral Loads (VLs). About 25% are undiagnosed. Estimates for the County are similar.
- DHSP is working to better quantify those HIV-, but at low- or high-risk for HIV to better target prevention. TLC+ and related efforts target those estimated to be HIV+ and aware, but not in care as well as linkage and maintenance.
- The presentation provided information on the current $24.6 million HIV prevention investment, but Mr. Pérez said it would change substantially in the next three months per new Federal operating expectations. Health Education/ Risk Reduction (HE/RR) will notably decline, while TLC+ and Partner Services will use different approaches.
- Meanwhile, RW clients migrating to Healthy Way LA (HWLA) will reduce Medical Outpatient (MO) services, but will still require wrap-around services to thrive. That may possibly require a Federal waiver from the 75%/25% rule.
- The County's planning response to NHAS focuses on: ECHPP, effective HIV prevention modeling such as Prevention for Positives, EIIHA, TLC+, data-driven planning and a focus on geographic relationships and high impact areas. The latter can specify not just areas with new infections but, e.g., areas where those with high viral loads are not in care.
- Key challenges are: diverse subpopulations requiring unique HIV responses; difficulty engaging communities of color in prevention and care due to infrequent, inconsistent health care access; delayed diagnosis and access to care; unstable funding; service delivery capacity especially in specific areas; adapting mature HIV/AIDS care and maturing prevention systems with more biomedical interventions to an HCR environment in flux.
- Opportunities include: improved data/data sharing; geospatial analysis; evidence used to guide programming; momentum from, e.g., NHAS, ECHPP, and the CDC Funding Opportunity Announcement (FOA); HRSA inclusion of EIIHA; development opportunities for the comprehensive plan and the HIV prevention plan, e.g., possible integration and inclusion of STDs, TB and social determinants; re-thinking the continuum in light of HCR; a single administrative agency; integration across morbidities and coordination of HIV care/treatment services across the continuum; increased blending of care and prevention funding; DPH support for streamlined, coordinated, evidence-based community planning.

3. ***Prevention Planning Committee (PPC)***:

- Mr. Smith reported there was a clear message at the National HIV Prevention Conference in August 2011 that, 30 years into the epidemic, it was essential to think differently about prevention. This is a perfect time to jointly reconsider how best to reach people. Many targeted for services know nothing about care and prevention distinctions – only services. The care and prevention silos that have been created must be eliminated.
- He agreed with Mr. Pérez about highlighting social determinants. Those working in prevention have discussed how to identify the undiagnosed and get them into care for years. There are multiple stigma issues that magnify other barriers, e.g., a gay teen evicted by family may need testing, but also housing to avert survival sex.
- The Commission/PPC Integration Task Force has had challenges, but also success in identifying joint areas in TLC+.
- Mr. Rosales acknowledged the bodies were walking into unknown territory as the situation changes across the country. He felt the County was ahead of other jurisdictions in service delivery, but the means will need to change.
- He admitted initial reluctance towards this meeting as being premature but, in planning it, came to realize it is important to start the conversation so the bodies can move forward collaboratively rather than separately. He remained concerned about moving too far prior to CDC guidance receipt so as not to have to backtrack.
- Ms. White asked how providers could overcome the "silo" mentality. Mr. Pérez replied DHSP would send provider partners a "save the date" flyer soon for a 12/1/2011, three-hour meeting at St. Anne's Conference Center to address the entirety of the environment, portfolio and paradigm shift underway in the County. It will update the impact of HCR, the ECHPP process, DHSP integration and include an overview of geomaps to help providers strategize.

- Mr. Smith felt familiarity with NHAS is critical to identify the unaware, how to link and engage them in care.
- Mr. Vincent-Jones said he hoped providers understand the importance of strategic planning on how their business models will respond to change. While not everything is definite yet, there are clear directions to use as a planning base. It is better to have a plan and revise it if needed than not have one.
- Mr. Johnson noted a sea change with HCR and Medicaid coverage expansion. The County removed exclusive HIV care designation so every Department of Health Services (DHS) contracted provider can serve PLWH. Those new partners need to be included in planning as DHSP is doing with its 12/1/2011 meeting.
- Ms. Watt pointed out that opening the HIV system to other providers expands access, but many of those providers are unlikely to be trained to serve the LGBT population or PLWH, e.g., regarding sexual health and partners.
- Mr. Land urged retaining individual identities and bringing their key aspects to the process. The approved priorities and allocations are flexible in order to accommodate change. He understands questioning how quickly to move forward, but felt stepping out boldly is the most effective way to remain competitive in this challenging new environment.
- Mr. Senterfitt praised inclusion of social determinants of health in plans. They are key to addressing prevention and unmet care need, yet are difficult and costly. He asked for thoughts on the process and intermediate targets.
- Mr. Pérez replied the first step was to make social determinants of health concepts part of public health planning and service delivery lexicons. They are not yet, but DPH increasingly asks program directors to incorporate them.
- A key challenge is the siloed funding approach to disease. He urged challenging funders to allow more flexibility to implement programs comprehensively. It is important to work closely across systems, such as with the Department of Mental Health (DMH), and with systems such as the school districts to show that a diploma is a prevention tool.
- Mr. Hamilton urged all to bring their experience to bear and keep moving forward rather than start and then retreat as has been done before. He noted his first concern when he entered the system was HIV, but he is now 55 and his needs are more complex if he is to continue to live well. An integrated system is key.

C. Acknowledge Barriers:

- Ms. Watt suggested noting those absent such as HOPWA; DMH; and representatives from education, the legal system and DPH, Substance Abuse Prevention and Control (SAPC) senior management. The Commission and PPC are identifying issues and moving forward, but need to find a way to bring other stakeholders to the table.
- Mr. Liso felt housing is a linchpin barrier to NHAS goals as, once lost, other barriers such as poverty, stigma and isolation increase. He complimented the Commission and DHSP on the recent HUD grant that will house and provide services for 50 families living with HIV. The County should also work collaboratively to support job development.
- Regarding timelines, Ms. Rumanes said the PPC is funded via the CDC. It released its FOA to public health departments, but not the HIV prevention planning guidance. The FOA requires a prevention plan which closely mirrors ECHPP within six months of 1/1/2012 implementation. DHSP submitted the application 9/12/2011. She noted guidance language has changed from “community planning” to “HIV prevention planning” to foster partnerships and evidence-based planning.
- Ms. Watt said the comprehensive plan is due to HRSA in May 2012 which aligns with the prevention plan.
- Ms. Burbie asked small groups to identify barriers/challenges to linkage, coordination and integration. Care and prevention have historically worked well, but now must show a united front. Group feedback followed:
  - Fear of change and loss of power.
  - Structural differences between the Commission and PPC and their different roles in the County.
  - Buy-in to prevention and education from related agencies, such as those providing mental health, dental care and housing services.
  - Clarity on goals in moving forward, e.g., a joint plan or a joint body?
  - Different and conflicting personalities.
  - Communicating among different providers, which often use different terminology or define words differently.
  - Communicating among silos from funders down through the provider level to better operationalize the continuum.
  - Geographic diversity of the County.
  - The Commission and PPC have historically coordinated with DPH, but many consumers will now be served through the Department of Health Services (DHS) requiring better coordination between the two departments.
  - Human nature gravitates toward the status quo.
  - Commission and PPC willingness to use transition resources for integrated community planning to provide a single venue to hear consumer voices and share scientific information.
  - Agency fear of funding losses, including how that affects collaboration among agencies.

- Lack of consumer education about changes in care pursuant to migration to Healthy Way LA (HWLA).
- Addressing how the RW system provides wrap-around services to address HWLA gaps.
- Lack of integrated HOPWA planning participation with the Commission and PPC of the Los Angeles County.
- Limited understanding of data and matrix on which funding, allocations and evaluations of progress will be increasingly measured. This is especially true due to County complexity versus other jurisdictions, difficulty of measuring social determinants and indicators such as undiagnosed not in care, and need to educate consumers.

D. Realistic Vision for Moving Forward: Ms. Burbie summarized challenges noted implicitly conclude that building the best integrated strategy will likely involve more than funders require, but is right to create an effective system for consumers.

8. BEST PRACTICE MODELS FOR JOINT PLANNING:

A. The Oregon Model:

- Ms. Yutzy, Consultant, noted people have talked for years about "collaboration," but language has already changed to "integration." HRSA sent her to Nevada ten years ago to facilitate a combined planning body for Part A (Las Vegas), Part B (Nevada) and the CDC statewide prevention group. The RW Part A Manual references processes now in place.
- Her first message was the County is behind. The Federal government uses what grantees do to craft guidance. In 2004, Wisconsin combined its planning process for prevention, care, STDs, Viral Hepatitis (VH) and TB. Connecticut, Michigan and Washington have combined processes. California's planning process was combined, split and then recombined.
- The County has led in other areas and can take best practices from other jurisdictions and adapt them to Los Angeles.
- Most jurisdictions that have led were state jurisdictions since Part B requires no planning process, but only a public hearing 120 days after the award. Most states have chosen to use a planning process, but it is fully adaptable.
- Part A, however, has strict requirements for planning councils. The CDC has also had strict requirements, but may be loosening them going forward. These stricter requirements make integrated planning challenging, but not impossible.
- In 2008, the first joint HRSA/CDC committee was formed for Prevention for Positives. A harbinger of the direction to come, HRSA and the CDC now routinely borrow language from each other's applications.
- HRSA and the CDC must respond to the 2010 NHAS and three 2010 and 2011 Institute of Medicine (IOM) Reports including a recommendation to link HIV testing with care and social services. Ms. Yutzy noted both HRSA and the CDC are scrambling to meet the tidal wave of requirements received in the last 18 months.
- She underscored that everyone should be familiar with both the NHAS and its implementation plan, which will guide activity going forward. For example, by the end of 2011 the CDC, HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA) will collaborate with states and localities on pilot initiatives for expanding the most promising models for integrating HIV testing, outreach, linkage and retention in care in high risk communities.
- While the 12 Cities Project is extremely important, models are already being reviewed for the next guidance and there are other activities to be implemented by the end of 2011 as well:
  - HRSA, in collaboration with the CDC, Veterans Administration (VA), HUD and other relevant agencies will develop plans that support health care providers and other staff who deliver HIV test results to facilitate linkage to care.
  - CDC, HRSA, SAMHSA and other relevant Health and Human Services (HHS) agencies will work with states, tribal governments, localities, and Community Based Organizations (CBOs) to promote co-location of HIV screening and care service providers to facilitate linkages to care/treatment and enhance referral systems within CBOs.
  - HRSA, CDC and SAMHSA will include language in grant announcements requiring integration of prevention and care services, including referral to clinical services. Now in place, HRSA and CDC grantees nationwide have been consulting each other to respond to questions about each others' programs. Few have one grantee for both.
  - HRSA, CDC and the HHS Office of the Secretary (OS) will develop recommendations for strengthening the parity, inclusion and meaningful representation of PLWH on planning and priority-setting bodies.
- HHS also met directly with PLWH recently and initiated a plan to ensure they are involved in planning and priority-setting processes called Meaningful Involvement of People with HIV/AIDS (MIPA). There were also calls to expand the 12 Cities Project, already a key NHAS component, to 12 counties.
- The County is part of the 12 Cities Project for cities with 44% of U.S. cases. Core principles are: concentrate resources where epidemic is most severe; coordinate Federal resources/actions across program lines; scale-up effective HIV prevention, care and treatment strategies; and innovate.
- Phase I, October 2010 through April 2011, constituted data collection and planning. Phase II, May 2011 through September 2011, is the response to the enhanced planning process with resources redirected to optimize outcomes.

- Mr. Pérez reported the County convened a scientific advisory committee to review prevention services while RAND Corporation systematically analyzed all County transmission patterns to measure interventions' regional effectiveness.
- ECHPP was funded nationally with $12 million in funds separate from and prior to the CDC FOA. For the first time, the CDC relied on 2008 living HIV cases to re-align funding based on the epidemic. The 12 Cities Project is not separately funded, but relies on coordination among local resources such as the VA, DMH, DHS, DPH, SAPC and FQHCs.
- Ms. Yutzy reported the RW application response has been to include prevention such as requiring testing results, TLC+ and coordination with prevention and disease control/intervention programs.
- The CDC application Category A for core required program components now requires information on linkage/retention in care, referral/linkage to other medical and social services, support for CD4 and VL reporting, and support for ART.
- Ms. Yutzy noted the integrated planning process in Oregon began in January 2010. The new body will have its inaugural meeting 1/25/2011. She emphasized that, while funders will provide more clarity over time, it is key to start now.
- Benefits of integrated planning include: efficiency of cross-sector planning, e.g., from shared staff, sites and equipment; supports NHAS; maximizes resources, e.g., by sharing strengths; supports stronger, more coordinated continuum of care/prevention; increases key stakeholder access; reduces duplicate efforts; identify/cooperate to fill continuum gaps; reduces member fatigue; increases HIV continuum transparency; improves services for affected/infected; improves cross-agency communication; and greater understanding of full epidemic and community.
- There are several integration levels. At a minimum, each program contributes a chapter to a plan that uses the same needs assessment data and epidemiology profile. The next level is periodic joint meetings. The third level is establishment of several committees that do joint planning. The final level is an integrated planning body.
- Oregon chose to include HIV, STDs and VH in planning. It began its integrated process with goals to: conceptualize a model, develop key policies and procedures, agree to a meeting schedule and develop a transition plan for the merger.
- The group used its first meeting to discuss fears and barriers. It was also essential for prevention and care groups to become thoroughly familiar with each other's work. Each program presented on its work using formatted slides to ensure information sharing compared "apples to apples." The body also reviewed each others' documents.
- Cultural differences arose, e.g., the prevention body application required applicants to reveal their sexual risk habits, as required by the CDC. Care members resisted disclosure. The Project Officer agreed to allow optional disclosure.
- It is critical to develop a unique planning framework rather than trying to insert one into another. Oregon identified each group's activities and the gaps for the unaware, notification of test results, referral to care, and linkage to care.
- Wisconsin developed a framework in 2004 with goals under prevention, testing, linkage and treatment.
- Key things to watch for: differing language/definitions; cultural differences, e.g., how meetings work; entrenched practices/processes; history, e.g., difficult past relationships; ownership/turf; process parity for all partners; funder requirements; communication break-downs; polarization versus use of diversity; lack of direction, e.g., clear meeting goals; differing cooperation norms/values; unequal involvement; perception of bias/attempts to influence process.
- Lessons learned are: take time to understand each other; transition planning will take longer than expected; do not ignore/dismiss differences; think "outside the box," e.g., people outside HIV, but expert in systems planning, FQHCs and the Affordable Care Act (ACA); address miscommunications quickly; "outside eyes" are valuable; skilled leadership is key, e.g., co-facilitators for full meetings and power in the Executive Committee composed of co-chairs from all groups; start with a shared vision; prioritize clear communication; provide a venue for all to identify "what's in it for me."

B. Questions and Answers: There were no questions.

10. TESTING LINKAGE TO CARE/TREATMENT PLUS (TLC+):

A. TLC+ Framework:

- Mr. King noted he and Ms. Watt are members of the Continuum Integration Task Force. Ms. Watt added she represented the Commission and Mr. King the PPC on the Task Force, which includes members of both groups.
- The Task Force began in mid-2010 and spent the first six months discussing its name and potential collaboration areas.
- A key lesson learned was that barriers, including fear significantly declined once the group identified TLC+ as a focus.
- TLC+ was identified as it clearly had elements of prevention and care/treatment and was imminent.
- TLC+ was categorized into testing and linkages and then subcategorized: testing into education, early intervention and HIV screening; linkages into planning, PrEP, PEP, special populations, integration and assessment. Those areas in turn were broken out and the Task Force asked three questions under each: What are we doing in care? What are we doing in prevention? What do we need to do going forward. Ten to 30 sample activities were identified for each line item.

- Ms. Watt noted some line items sparked long discussions, e.g., where an intervention starts in identifying effective components of patient navigation models. Initially it often took a full meeting to determine care, prevention and shared activities for one item. Improved understanding of the language helped the Task Force both move more quickly and, significantly, move beyond identifying where activities happen and who does them according to the funding source. Instead, the focus is on what the client needs at any point along the continuum which requires collaboration.
- She expected a joint TLC+ Plan by the end of 2011 to keep people negative and find, engage and retain PLWH in care.
- Regarding lessons learned, Ms. Watt emphasized a common understanding of terminology. Mr. King noted people came to the table with different goals from full integration to concerns with the process. It took time to agree to explore possible integration areas and choose the TLC+ Plan. He felt it key to identify a common intention and purpose.
- Regarding structure, Ms. Watt said everyone must commit: to attend meetings, read each other's plans to familiarize one's self with each other's requirements, and keep an open mind. Staff and technical support was sufficient.
- Several added each body has different processes, so it is also necessary to be familiar with those. Presentation at each other's meetings on their bodies' structure and processes was helpful as was taking the time to build relationships.
- Ms. Watt cautioned all not to declare goals for integrated activities prematurely in order to avert undue fears, but to use the meeting to hear examples of shared work and then consider options.

11. ACTION PLANNING:

- Ms. Burbie emphasized remaining open and determined to identify tangible opportunities to advance both the immediate and overarching movement toward integration. Identify how to overcome barriers, develop trust and monitor progress.
- The body broke into work groups which brought back the following thoughts:
  - Group 1: Use the opportunity of a six-month timeline for plans to identify a comprehensive plan as the task; identify a goal to end the HIV epidemic in the County; include other groups in the planning process; and ensure foundational education on the Commission and PPC such as on terminology, structures, data and Federal requirements.
  - Group 2: Expand the Continuum Integration Task Force with more members, tasks and joint planning; hold more joint Commission/PPC meetings with measurable outcomes within next six months; identify other bodies, such as HOPWA, to participate in joint meetings; educate Commission and PPC about HRSA and CDC requirements; identify and dispel Commission/PPC myths and educate about the structures; and discuss new funding for HE/RR for high-risk populations.
  - Group 3: Merge bodies to maximize funds, improve services and provide a more comprehensive approach to health and wellness; encourage agency leadership to solicit ideas from the rank-and-file via an educational meeting; and monitor strategic planning with dashboards. Barriers noted were need for education on language, cultural and training/services differences, and the need to break down institutional barriers.
  - Group 4: Develop comprehensive plan as the task; hold integration planning meetings beginning with agreed subject areas; regular educational leadership meetings; engage third party as facilitator.
  - Group 5: Timing of Comprehensive Care Plan, Prevention Plan and NHAS noted as opportunity for new comprehensive plan; clarify language through education; learn from existing system to inform a new body. Address barriers with focus on Commission and PPC similarities, not differences; educate body about each other to dispel misconceptions; and address greater provider participation in PPC by encouraging similar participation as in the Commission.
  - Group 6: Use ECHPP as template to lace prevention and care plans together as it is being used for the prevention plan; build on integrated plan to integrate bodies; use PPC prevention modeling with Commission financial modeling to improve allocations. Address education by learning how each body functions, reasons and constraints, plus differing terminology; bring DHS and new HCR stakeholders into process by modeling Commission/PPC ability to plan together.
  - Group 7: Translate lessons learned from TLC+ work; be productive rather than reactive, e.g., through joint projects such as needs assessment; interlink task groups where possible; reduce service duplication; identify clients at earlier disease stage. Ensure structure addresses so a possibly larger group retains good dialogue; evaluate joint project monitoring.
  - Group 8: Uniting groups strengthens advocacy, provider unity and collaboration. Address barriers of need to participate with open mind and need for department, agency, provider and consumer participation. Monitor progress by sharing information, more internal Commission/PPC discussions and an Integration Task Force survey of both bodies on issues.
- Ms. Burbie complimented engagement in the process. She felt there was consensus on the following:
  - Develop one comprehensive plan that meets needs of both bodies and uses ECHPP as a framework;
  - Be intentional in adding other stakeholders at the table to holistically address services and maximize County resources;
  - Increase Commission/PPC education about each other as well as education about HRSA and the CDC to better address comprehensive planning and debunk myths, build trust, and act as a vehicle for potential integration.

- Mr. Copeland felt it was too soon to combine plans. Three DPH programs have just been collapsed into one and already there is a proposal to collapse two plans into one. He suggested developing areas of overlap jointly instead.
- Ms. Watt said it was unnecessary to merge bodies to integrate plan components. TLC+ work showed smaller groups and learning about each other led to progress. Small Commission/PPC groups could work on plan chapters with a commonality.
- She also felt most people do not understand different care sources such as the DHS HWLA program not bound by, e.g., the Commission's standards of care. Mr. Vega-Matos noted there are about 15,000 RW patients. Some 5,000 will migrate to HWLA which covers medical outpatient, some specialty care and a few other services. Other funding will be needed for wrap-around services. DHSP is working with DHS and providers while informing the Commission and Consumer Caucus.
- Ms. Chamberlain said consumers must have a mechanism to register compliments or complaints at providers with no history of serving the HIV population to ensure funds are used well. Mr. Vega-Matos said most people will be able to remain in their HIV medical homes, but will have access to additional services not covered by RW. Meanwhile, DHSP is working to develop a mechanism for people to know which clinics have an HIV specialty and educate providers about consumer needs.
- Mr. Fox added most HWLA discussion focuses on care, but it is also a prevention opportunity as many low-income, high-risk people will be able to access free care and prevention services. Both bodies should support that. Others noted people of color and LGBT are hard to engage in care or prevention, so current agencies with that expertise are valuable.
- Mr. Land encouraged all to personally invest in a comprehensive plan and asked about ways to encourage it. Ms. Watt suggested review of the NHAS operational plans and ECHPP. The CCP Task Force timeline includes stakeholder meetings.
- Ms. Rumanes noted ECHPP is the only funded program implementing NHAS. The document had to be written in four months, so there was little community input. Requirements include surveillance, community VL and linkage to care. The prevention plan is due within six months of the FOA, but the CDC allowed jurisdictions to use ECHPP. DHSP and the PPC are already working furiously to address these changes and that affects how the PPC comes to additional change.
- Mr. Kochems added ECHPP happened because the CDC required it on a short timeline. Many hard discussions have already been held in various groups. He suggested a facilitator could help with Commission, PPC and DHSP discussions.
- Mr. Aviña noted prevention grantees have historically used the prevention plan to plan services and respond to RFPs. A countywide prevention and care plan would help providers plan better services, so he urged moving forward. Ms. Watt noted the CCP Task Force has used that model of a readily accessible, usable plan in their work.

13. SUMMARY AND CLOSING:

- Ms. Burbie summarized that the group had developed consensus for an integrated plan while noting issues and concerns. She suggested the Continuum Integration Task Force recommend next steps based on the discussion.
- Mr. Stewart noted the Commission retained quorum, so could vote. The joint body could also adopt a recommendation to the PPC. The Continuum Integration Task Force could begin work based on direction from one partner, i.e., the Commission, pending ratification by the PPC. If the PPC ratifies, work could proceed. If not, then other action would be needed. Mr. Smith supported referring work to the Continuum Integration Task Force as the PPC would not meet until November.
- ➲ The Commission and PPC Executive Committees will appoint additional people to the Continuum Integration Task Force to broaden input until the Task Force identifies what additional skill sets are needed and recruits for them.
- ➲ All partners will continue structural issue discussions, e.g., whether to merge the CCP and Integration Task Forces.

MOTION 2: Contingent upon the Prevention Planning Committee's (PPC's) approval/ratification, the Commission adopts the intent and the goal to develop an integrated comprehensive HIV plan, including both care and prevention, and charges the Continuum Integration Task Force with developing a work plan, timeline and schedule, and completing of the comprehensive HIV plan by May 2012. ***(Passed by Commission Consensus)***.

14. ANNOUNCEMENTS:

- Mr. Hamilton announced the "Breaking the Silence Conference III: Talking to Your Man About Sex and Health," 11/5/2011, Charles Drew University High School. He urged providers and HIV+/HIV- African-American women and Latina clients attend.
- Positive Parolee Network (PPN) is a new Center for Health Justice program in collaboration with Spectrum/Charles Drew University and the Oasis Clinic. PPN provides consistent, clinical, supervised, peer-driven support and linkage to medical care for PLWH paroling from California State prisons to the County to engage and retain them in treatment. PPN provides a cell phone and minutes for linkage. All ethnicities and genders are welcome. It is not necessary to be an Oasis Clinic client.
- Men In Life Environment (MILE) is a behavioral intervention for sexually active men recently incarcerated in prison or jail.
- Mr. Goddard announced the Annual Aid for AIDS Best in Drag Show will be at the Orpheum Theater on 10/9/2011.
- Mr. Johnson introduced Dr. Joseph Cadden, representing DHS on the Health Care Provider seat. Mr. Johnson leaves DHS on 10/13/2011 to join Planned Parenthood, Los Angeles as Chief Administrative Officer.

- Dr. Lilia Espinoza, USC AETC, has also joined the Commission as the AETCs/Medical Schools seat representative.
- JWCH will host a Masquerade Party fundraiser at the House of Blues on 10/28/2011. Invitations will go out shortly.
- The Annual Alianza Latino Caucus on HIV/AIDS Conference will be 10/15/2011 at the Japanese American Culture and Community Center. Information will be distributed via Commission and PPC lists.
- The PPC has voted Mr. Gutierrez, LA Gay and Lesbian Center, their next Community Co-Chair. His term starts January 2012.
- Mr. Vega-Matos announced a website for HWLA questions: www.HWLAproviderquestions@ph.lacounty.gov.

15. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 4:35 pm.

A. Roll Call (**Present)**:

- *Commission*: Aviña, Bailey/Lewis, Cadden, Espinoza, Fox*, James, Johnson, Kochems, Liso, Lopez, O'Malley, Rivera, Sotomayor, Vega-Matos, Washington-Hendricks, Watt*
- *PPC*: Carlos, Copeland, Enfield, Fox*, Green, Gutierrez, King, Rotenberg, Rumanes, Terry Smith, Watt*, Young

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Contingent upon the Prevention Planning Committee's (PPC's) approval/ratification, the Commission adopts the intent and the goal to develop an integrated comprehensive HIV plan, including both care and prevention, and charges the Continuum Integration Task Force with developing a work plan, timeline and schedule, and completing of the comprehensive HIV plan by May 2012.	***Passed by Commission Consensus***	**MOTION PASSED**